SUMMARY OF BENEFITS
REGENCE BREAKTHRU 70
(A PREFERRED PLAN)

Regence

Regence BlueShield is an Independent Licensee of the Blue Cross and Blue Shield Association

For medically necessary services rendered by a Preferred Plan, participating, or recognized provider, the benefits of this plan will be provided at the percentage of the allowed amount as specified below after the deductible has been met. Unless otherwise specified, all benefits are subject to the annual deductible in addition to any copays and coinsurance.

When you have reached the annual out-of-pocket coinsurance maximum, this plan will provide benefits at 100% of the allowed amount for the remainder of the calendar year for the services of Preferred Plan providers only, unless otherwise specified. Any balances of charges not covered by this plan will be your responsibility to pay.

The annual deductible, copays, prescription drugs, outpatient rehabilitation, vision hardware, and most participating provider services do not apply to the annual out-of-pocket coinsurance amount.

Benefits	Preferred Plan Provider	Participating Provider
Annual Deductible Copays, prescription drugs, preventive care, and the routine eye exam do not count toward the deductible. Family deductible is met when three or more covered family members reach the equivalent of three individual deductible amounts in a calendar year	$1,000 per individual/$3,000 per family or $3,000 per individual/$9,000 per family	
Lifetime maximum	$2,000,000 per individual	
Annual Out-of-Pocket Coinsurance Amount Family out-of-pocket coinsurance amount is met when three or more covered family members reach the equivalent of three individual out-of-pocket coinsurance amounts in a calendar year	$5,000 per person $15,000 per family	No out-of-pocket maximum
Professional Services	(unless specified otherwise)	
Visits in the office, home, and outpatient hospital; not subject to deductible	100% after $30 per-visit copay	100% after $40 per-visit copay
Outpatient diagnostic x-ray and laboratory services; and other professional services; subject to deductible		
Coverage includes the services of physicians, osteopaths, naturopaths, and other eligible health care professional providers	70%	50%
Hospital Facility (Inpatient and Outpatient)***** Including diagnostic x-ray and laboratory $100 copay per emergency room visit (waived if admitted)	70%	50%
Acupuncture 12 visits per calendar year maximum	70%	50%
Ambulance Services** Ground services: $2,000 per calendar year maximum	70%	70%
Blood Bank**	70%	70%
Home Health and Hospice Home Health – 130 visits per calendar year maximum Hospice – 6 months maximum	70%	70%
Home Medical Equipment $2,500 per calendar year maximum	70%	50%
Home Phototherapy	70%	70%
Infusion Therapy Growth hormone treatment is limited to $25,000 per calendar year	70%	50%
Mammography Routine mammograms not subject to deductible	70%	50%
Maternity	70%	50%
Mental Disorders Inpatient – 8 days per calendar year Outpatient – 12 visits per calendar year	70%	50%
Occupational Injury (provided for the subscriber only)	same as any condition	
Phenylketonuria (PKU) Formulas Not subject to waiting periods	70%	70%

(over)

Prescription Drugs $3,000 per calendar year maximum; not subject to deductible Generic Formulary Brand-Name Formulary Non-Formulary	100% after $10 Retail copay / 100% after $20 Mail Order copay 70% 50%	
Preventive Care $200 per calendar year maximum; not subject to deductible Routine exams, immunizations, well child care, and routine cancer screenings including preventive surgeries (routine colorectal cancer screenings not subject to maximum)	70%	50%
Prostate Cancer Screening Routine prostate cancer screenings not subject to deductible	70%	50%
Prostheses and Orthotics	70%	50%
Rehabilitation Inpatient – $4,000 per calendar year maximum Outpatient – $2,000 per calendar year maximum	70%	50%
Skilled Nursing Facility 30 days per calendar year maximum	*	70%
Special Equipment and Supplies	70%	70%
Spinal Manipulations 10 manipulations per calendar year maximum	70%	50%
Transplants $350,000 lifetime maximum; $50,000 per transplant donor organ procurement maximum; $2,500 per transplant travel and lodging maximum; 12-month waiting period	70%	50%
Vision Care (not subject to deductible) One routine eye exam per calendar year Vision hardware: $200 per calendar year maximum for all providers	100% after $30 copay ***	100% after $40 copay 100%

*At this time, this service is provided only by participating providers.
**At this time, these services are provided only by recognized providers.
***At this time, this service is provided only by participating or recognized optical providers.
****Services and supplies required to treat a medical emergency will be provided at the Preferred Plan payment level of benefits.

Cost Containment Provisions: All hospital and skilled nursing facility admissions must be medically necessary. Preadmission approval is required for all inpatient admissions outside the service area if you seek care from providers who have not contracted with a Blue Cross and/or Blue Shield plan, except for emergency services or maternity admissions.

Emergency Care: Emergency benefits will be provided at the level specified for a Preferred Plan provider. In the event of a medical emergency, treatment by a provider not normally covered under this plan will be recognized for a 24-hour period or for such additional time as is reasonably required to come under the care of a Preferred Plan or participating provider. Benefits will be based on the recognized provider's actual charge for the service.

Copay: There is a per-visit copay for each office call/home visit billed as such by a provider in the office, home, or hospital outpatient department (waived for surgery, for radiation and chemotherapy, for spinal manipulations, or if you are directly admitted to the hospital as an inpatient). Copays do not apply toward the deductible or to the out-of-pocket coinsurance amount.

Care Outside the Service Area: All care received outside the service area will be paid the same as in the service area if you use a Preferred Plan or participating provider. Payment will be based on the allowed amount. To receive the highest benefit level, you must receive services from a Preferred Plan provider. If there is no Preferred Plan provider network in an area, benefits will be provided for care received from a participating provider at the level specified for Preferred Plan providers. Benefits will be provided for care received from a recognized provider at the level specified for Preferred Plan providers only, if there is no local Blue Cross and/or Blue Shield participating provider network in a particular area and for medical emergencies. Call 1-800-810-BLUE (2583) for names of Preferred Plan or participating providers with the local Blue Cross and/or Blue Shield plan. When you need health care outside of the United States or its territories, call the BlueCard Worldwide Service Center at 1-800-810-BLUE or call collect at 1-804-673-1177. If you are admitted to a hospital while traveling outside the service area, you must contact the Company within 24 hours to receive full plan benefits. If you meet all requirements, inpatient benefits will be provided at the level specified for Preferred Plan providers for like services and supplies.

Waiting Periods: No benefits are provided for treatment relating to a transplant until you have been covered under this plan for 12 consecutive months. This waiting period will be reduced by any time that you were covered under prior plan(s) that qualify as creditable coverage. No benefits will be provided for preexisting conditions, including postnatal treatment of pregnancy, delivery, and voluntary termination of pregnancy, until you have been covered under this plan for nine consecutive months, unless you were continuously covered for at least nine months under the immediately preceding creditable plan.

This is a brief summary of benefits; it is not a certificate of coverage. For full coverage provisions, including a description of waiting periods, limitations, and exclusions, refer to the plan contract. myRegence.com is designed to advise you on health care and lifestyle options, navigate you through the health care system, and reward you who make healthy choices. Go to www.myRegence.com and view claims; get fitness and nutrition tips; learn about medical conditions, medications and formulary information; search for doctors; and research cost and care options.

SUMMARY OF BENEFITS

REGENCE BREAKTHRU 50 (A PREFERRED PLAN)

Regence

Regence BlueShield is an Independent Licensee of the Blue Cross and Blue Shield Association

For medically necessary services rendered by a Preferred Plan, participating, or recognized provider, the benefits of this plan will be provided at the percentage of the allowed amount as specified below after the deductible has been met. Unless otherwise specified, all benefits are subject to the annual deductible in addition to any copays and coinsurance.

When you have reached the annual out-of-pocket coinsurance maximum, this plan will provide benefits at 100% of the allowed amount for the remainder of the calendar year for the services of Preferred Plan providers only, unless otherwise specified. Any balances of charges not covered by this plan will be your responsibility to pay.

The annual deductible, copays, outpatient rehabilitation, and most participating provider services do not apply to the annual out-of-pocket coinsurance amount.

Benefits	**Preferred Plan Provider**	**Participating Provider**
Annual Deductible Copays do not count toward the deductible. Family deductible is met when three or more covered family members reach the equivalent of three individual deductible amounts in a calendar year	$2,500 per individual/$7,500 per family or $5,000 per individual/$15,000 per family	
Lifetime maximum	$2,000,000 per individual	
Annual Out-of-Pocket Coinsurance Amount Family out-of-pocket coinsurance amount is met when three or more covered family members reach the equivalent of three individual out-of-pocket coinsurance amounts in a calendar year	$10,000 per person $30,000 per family	No out-of-pocket maximum
Professional Services Including diagnostic x-ray and laboratory. Coverage includes the services of physicians, osteopaths, naturopaths, and other eligible health care professional providers	50% (unless specified otherwise)	50%
Hospital Facility (Inpatient and Outpatient) Including diagnostic x-ray and laboratory $100 copay per emergency room visit (waived if admitted)	50%	50%
Acupuncture 12 visits per calendar year maximum	50%	50%
Ambulance Services** Ground services: $2,000 per calendar year maximum	50%	50%
Blood Bank**	50%	50%
Colorectal Cancer Screening	50%	50%
Home Health and Hospice Home Health – 130 visits per calendar year maximum Hospice – 6 months maximum	50%	50%
Home Medical Equipment $2,500 per calendar year maximum	50%	50%
Home Phototherapy	50%	50%
Infusion Therapy Growth hormone treatment is limited to $25,000 per calendar year	50%	50%
Mammography	50%	50%
Mental Disorders Inpatient – 8 days per calendar year Outpatient – 12 visits per calendar year	50%	50%
Occupational Injury (provided for subscriber only)	same as any condition	

(over)

Phenylketonuria (PKU) Formulas Not subject to waiting periods	50%	50%
Prostate Cancer Screening	50%	50%
Prostheses and Orthotics	50%	50%
Rehabilitation Inpatient – $4,000 per calendar year maximum Outpatient – $2,000 per calendar year maximum	50%	50%
Skilled Nursing Facility 30 days per calendar year maximum	*	50%
Special Equipment and Supplies	50%	50%
Spinal Manipulations 10 manipulations per calendar year maximum	50%	50%
Transplants $350,000 lifetime maximum; $50,000 per transplant donor organ procurement maximum; $2,500 per transplant travel and lodging maximum; 12-month waiting period	50%	50%

*At this time, this service is provided only by participating providers.
**At this time, these services are provided only by recognized providers.

Cost Containment Provisions: All hospital and skilled nursing facility admissions must be medically necessary. Preadmission approval is required for all inpatient admissions outside the service area if you seek care from providers who have not contracted with a Blue Cross and/or Blue Shield plan, except for emergency services.

Emergency Care: Emergency benefits will be provided at the level specified for a Preferred Plan provider. In the event of a medical emergency, treatment by a provider not normally covered under this plan will be recognized for a 24-hour period or for such additional time as is reasonably required to come under the care of a Preferred Plan or participating provider. Benefits will be based on the recognized provider's actual charge for the service.

Care Outside the Service Area: All care received outside the service area will be paid the same as in the service area if you use a Preferred Plan or participating provider. Payment will be based on the allowed amount. To receive the highest benefit level, you must receive services from a Preferred Plan provider. If there is no Preferred Plan provider network in an area, benefits will be provided for care received from a participating provider at the level specified for Preferred Plan providers. Benefits will be provided for care received from a recognized provider at the level specified for Preferred Plan providers only, if there is no local Blue Cross and/or Blue Shield participating provider network in a particular area and for medical emergencies. Call 1-800-810-BLUE (2583) for names of Preferred Plan or participating providers with the local Blue Cross and/or Blue Shield plan. When you need health care outside of the United States or its territories, call the BlueCard Worldwide Service Center at 1-800-810-BLUE or call collect at 1-804-673-1177. If you are admitted to a hospital while traveling outside the service area, you must contact the Company within 24 hours to receive full plan benefits. If you meet all requirements, inpatient benefits will be provided at the level specified for Preferred Plan providers for like services and supplies.

Waiting Periods: No benefits are provided for treatment relating to a transplant until you have been covered under this plan for 12 consecutive months. This waiting period will be reduced by any time that you were covered under prior plan(s) that qualify as creditable coverage. No benefits will be provided for preexisting conditions until you have been covered under this plan for nine consecutive months, unless you were continuously covered for at least nine months under the immediately preceding creditable plan.

This is a brief summary of benefits; it is not a certificate of coverage. For full coverage provisions, including a description of waiting periods, limitations, and exclusions, refer to the plan contract. myRegence.com is designed to advise you on health care and lifestyle options, navigate you through the health care system, and reward you who make healthy choices. Go to www.myRegence.com and view claims; get fitness and nutrition tips; learn about medical conditions, medications and formulary information; search for doctors; and research cost and care options.

SUMMARY OF BENEFITS
Regence NowSelect℠
(A PREFERRED PLAN)

Regence

Regence BlueShield is an Independent Licensee of the Blue Cross and Blue Shield Association

For medically necessary services rendered by a Preferred Plan, participating, or recognized provider, the benefits of this plan will be provided at the percentage of the allowed amount as specified below after the deductible has been met. Unless otherwise specified, all benefits are subject to the annual deductible in addition to any copays and coinsurance.

When you have reached the annual out-of-pocket coinsurance maximum, this plan will provide benefits at 100% of the allowed amount for the remainder of the calendar year for the services of Preferred Plan providers only, unless otherwise specified. Any balances of charges not covered by this plan will be your responsibility to pay.

The annual deductible, copays, outpatient rehabilitation, and most participating provider services do not apply to the annual out-of-pocket coinsurance amount.

Benefits	Preferred Plan Provider	Participating Provider
Annual Deductible Copays and preventive care do not count toward the deductible. Family deductible is met when three or more covered family members reach the equivalent of three individual deductible amounts in a calendar year	$2,500 per individual/$7,500 per family or $5,000 per individual/$15,000 per family or $7,500 per individual/$22,500 per family or $10,000 per individual/$30,000 per family	
Lifetime maximum	$2,000,000 per individual	
Annual Out-of-Pocket Coinsurance Amount Family out-of-pocket coinsurance amount is met when three or more covered family members reach the equivalent of three individual out-of-pocket coinsurance amounts in a calendar year	$5,000 per person $15,000 per family	No out-of-pocket maximum
Professional Services	(unless specified otherwise)	
Not subject to deductible - First four visits in the office, home, or outpatient hospital per calendar year after office-visit copay and first $400 outpatient diagnostic x-ray and laboratory services	100% after $35 per office-visit copay	100% after $35 per office-visit copay
Subject to deductible - Fifth and subsequent visits in the office, home, or outpatient hospital per calendar year after office-visit copay; outpatient x-ray and lab above the first $400/calendar year maximum; and all other professional services not billed as an office visit (i.e., x-ray, laboratory, medical procedures)	80%	50%
Hospital Facility (Inpatient and Outpatient)*** Including diagnostic x-ray and laboratory $100 copay per emergency room visit (waived if admitted)	80%	50%
Acupuncture 12 visits per calendar year maximum	80%	50%
Ambulance Services** Ground services: $2,000 per calendar year maximum	80%	80%
Blood Bank**	80%	80%
Home Health and Hospice Home Health – 130 visits per calendar year maximum Hospice – 6 months maximum	80%	80%
Home Medical Equipment $2,500 per calendar year maximum	80%	50%
Home Phototherapy	80%	80%
Infusion Therapy Growth hormone treatment is limited to $25,000 per calendar year	80%	50%
Mammography	same as any condition	
Mental Disorders Inpatient – 8 days per calendar year Outpatient – 12 visits per calendar year	80%	50%
Occupational Injury (provided for the subscriber only)	same as any condition	
Phenylketonuria (PKU) Formulas Not subject to waiting periods	80%	80%

(over)

Preventive Care $200 per calendar year maximum; not subject to deductible Routine exams, immunizations, well child care, and routine cancer screenings including preventive surgeries (routine colorectal cancer screenings not subject to maximum) Routine mammography and routine prostate cancer screening services are not covered under Preventive Care and are not subject to maximum	80%	50%
Prostate Cancer Screening	same as any condition	
Prostheses and Orthotics	80%	50%
Rehabilitation Inpatient – $4,000 per calendar year maximum Outpatient – $2,000 per calendar year maximum	80%	50%
Skilled Nursing Facility 30 days per calendar year maximum	*	80%
Special Equipment and Supplies	80%	80%
Spinal Manipulations 10 manipulations per calendar year maximum	80%	50%
Transplants $350,000 lifetime maximum; $50,000 per transplant donor organ procurement maximum; $2,500 per transplant travel and lodging maximum; 12-month waiting period	80%	50%

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**At this time, these services are provided only by recognized providers.
***Services and supplies required to treat a medical emergency will be provided at the Preferred Plan payment level of benefits.

Cost Containment Provisions: All hospital and skilled nursing facility admissions must be medically necessary. Preadmission approval is required for all inpatient admissions outside the service area if you seek care from providers who have not contracted with a Blue Cross and/or Blue Shield plan, except for emergency services.

Emergency Care: Emergency benefits will be provided at the level specified for a Preferred Plan provider. In the event of a medical emergency, treatment by a provider not normally covered under this plan will be recognized for a 24-hour period or for such additional time as is reasonably required to come under the care of a Preferred Plan or participating provider. Benefits will be based on the recognized provider's actual charge for the service.

Copay: There is a per-visit copay for each office call/home visit billed as such by a provider in the office, home, or hospital outpatient department (waived for surgery, for radiation and chemotherapy, for spinal manipulations, or if you are directly admitted to the hospital as an inpatient). Copays do not apply toward the deductible or to the out-of-pocket coinsurance amount.

Care Outside the Service Area: All care received outside the service area will be paid the same as in the service area if you use a Preferred Plan or participating provider. Payment will be based on the allowed amount. To receive the highest benefit level, you must receive services from a Preferred Plan provider. If there is no Preferred Plan provider network in an area, benefits will be provided for care received from a participating provider at the level specified for Preferred Plan providers. Benefits will be provided for care received from a recognized provider at the level specified for Preferred Plan providers only, if there is no local Blue Cross and/or Blue Shield participating provider network in a particular area and for medical emergencies. Call 1-800-810-BLUE (2583) for names of Preferred Plan or participating providers with the local Blue Cross and/or Blue Shield plan. When you need health care outside of the United States or its territories, call the BlueCard Worldwide Service Center at 1-800-810-BLUE or call collect at 1-804-673-1177. If you are admitted to a hospital while traveling outside the service area, you must contact the Company within 24 hours to receive full plan benefits. If you meet all requirements, inpatient benefits will be provided at the level specified for Preferred Plan providers for like services and supplies.

Waiting Periods: No benefits are provided for treatment relating to a transplant until you have been covered under this plan for 12 consecutive months. This waiting period will be reduced by any time that you were covered under prior plan(s) that qualify as creditable coverage. No benefits will be provided for preexisting conditions, until you have been covered under this plan for nine consecutive months, unless you were continuously covered for at least nine months under the immediately preceding creditable plan.

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SUMMARY OF BENEFITS

INDIVIDUAL REGENCE HSA HEALTHPLAN COMPREHENSIVE

Regence

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For medically necessary services rendered by a Preferred Plan, participating, or recognized provider, the benefits of this plan will be provided at the percentage of the allowed amount as specified below after the deductible has been met. Unless otherwise specified, all benefits are subject to the annual deductible in addition to any coinsurance. When you, or you and your family, have reached the annual out-of-pocket maximum, this plan will provide benefits at 100% of the allowed amount for the remainder of the calendar year for the services of Preferred Plan providers only, unless specified otherwise. Any balances of charges not covered by this plan will be your, or you and your family's, responsibility to pay. Most services provided by participating providers do not apply toward the annual out-of-pocket maximum.

Benefits	Preferred Plan Provider	Participating Provider
Annual Deductible Family deductible applies when the subscriber and one or more dependents are enrolled. Prior to benefits being paid for any family member, the entire family deductible must be met.	$1,500 per member/$3,000 per family	
Lifetime maximum	$2,000,000 per member	
Annual Out-of-Pocket Amount The total amount of coinsurance and deductible amount you, or you and your family, are responsible to pay during a calendar year for covered services, after which the plan will provide 100% of the allowed amount for the remainder of that calendar year, unless otherwise specified. Any balances of charges not covered by this plan will be your, or you and your family's, responsibility to pay. The family out-of-pocket amount applies when the subscriber and one or more dependents are enrolled. Prior to benefits being paid for any family member at 100%, the entire family out-of-pocket maximum must be met.	$5,000 per member $10,000 per family	No out-of-pocket maximum
Professional Services Including diagnostic x-ray and laboratory. Coverage includes the services of physicians, osteopaths, naturopaths, and other eligible health care professional providers.	80% (unless specified otherwise)	60%
Hospital Facility (Inpatient and Outpatient)*** Including diagnostic x-ray and laboratory	80%	60%
Acupuncture 12 visits per calendar year maximum	80%	60%
Ambulance Services** Ground services: $2,000 per calendar year maximum	80%	80%
Blood Bank**	80%	80%
Home Health and Hospice Home Health – 130 visits per calendar year maximum Hospice – 6 months maximum	80%	80%
Home Medical Equipment $2,500 per calendar year maximum	80%	60%
Home Phototherapy	80%	80%
Infusion Therapy Growth hormone treatment is limited to $20,000 per calendar year	80%	60%
Mammography Routine mammograms not subject to deductible	80%	60%
Maternity	80%	60%

(over)

Mental Disorders Inpatient – 8 days per calendar year Outpatient – 12 visits per calendar year	80%	60%
Newborn Care	80%	60%
Occupational Injury (provided for the subscriber only)	80%	60%
Phenylketonuria (PKU) Formulas Not subject to waiting periods	80%	80%
Prescription Drugs $2,000 per calendar year maximum; closed formulary	*	50%
Preventive Care (not subject to deductible)	80%	60%
Prostate Cancer Screening Routine prostate cancer screenings not subject to deductible	80%	60%
Prostheses and Orthotics	80%	60%
Rehabilitation Inpatient - $4,000 per calendar year maximum Outpatient - $2,000 per calendar year maximum	80%	60%
Skilled Nursing Facility 30 days per calendar year maximum	*	80%
Special Equipment and Supplies	80%	80%
Spinal Manipulations 10 manipulations per calendar year maximum	80%	60%
Transplants $350,000 lifetime maximum; 12-month waiting period	80%	60%

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**At this time, these services are provided only by recognized providers.
***Services and supplies required to treat a medical emergency will be provided at the Preferred Plan payment level of benefits.

Cost Containment Provisions: All hospital and skilled nursing facility admissions must be medically necessary. Preadmission approval is required for all inpatient admissions outside the service area if you seek care from providers who have not contracted with a Blue Cross and/or Blue Shield plan, except for emergency services.

Emergency Care: Emergency benefits will be provided at the level specified for a Preferred Plan provider. In the event of a medical emergency, treatment by a provider not normally covered under this plan will be recognized for a 24-hour period or for such additional time as is reasonably required to come under the care of a Preferred Plan or participating provider. Benefits will be based on the recognized provider's actual charge for the service.

Care Outside the Service Area: All care received outside the service area will be paid the same as in the service area if you use a Preferred Plan or participating provider. Payment will be based on the allowed amount. To receive the highest benefit level, you must receive services from a Preferred Plan provider. If there is no Preferred Plan provider network in an area, benefits will be provided for care received from a participating provider at the level specified for Preferred Plan providers. Benefits will be provided for care received from a recognized provider at the level specified for Preferred Plan providers only, if there is no local Blue Cross and/or Blue Shield participating provider network in a particular area and for medical emergencies. Call 1-800-810-BLUE (2583) for names of Preferred Plan or participating providers with the local Blue Cross and/or Blue Shield plan. When you need health care outside of the United States or its territories, call the BlueCard Worldwide Service Center at 1-800-810-BLUE or call collect at 1-804-673-1177. If you are admitted to a hospital while traveling outside the service area, you must contact the Company within 24 hours to receive full plan benefits. If you meet all requirements, inpatient benefits will be provided at the level specified for Preferred Plan providers for like services and supplies.

Waiting Periods: No benefits are provided for treatment relating to a transplant until you have been covered under this plan for 12 consecutive months. This waiting period will be reduced by any time that you were covered under prior plan(s) that qualify as creditable coverage. No benefits will be provided for preexisting conditions, including postnatal treatment of pregnancy, delivery, and voluntary termination of pregnancy, until you have been covered under this plan for nine consecutive months, unless you were continuously covered for at least nine months under the immediately preceding creditable plan.

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SUMMARY OF BENEFITS
INDIVIDUAL
REGENCE HSA HEALTHPLAN

Regence

Regence BlueShield is an Independent Licensee of the Blue Cross and Blue Shield Association

For medically necessary services rendered by a Preferred Plan, participating, or recognized provider, the benefits of this plan will be provided at the percentage of the allowed amount as specified below after the deductible has been met. Unless otherwise specified, all benefits are subject to the annual deductible in addition to any coinsurance. When you, or you and your family, have reached the annual out-of-pocket maximum, this plan will provide benefits at 100% of the allowed amount for the remainder of the calendar year for the services of Preferred Plan providers only, unless specified otherwise. Any balances of charges not covered by this plan will be your, or you and your family's, responsibility to pay. Most services provided by participating providers do not apply toward the annual out-of-pocket maximum.

Benefits	Preferred Plan Provider	Participating Provider
Annual Deductible Family deductible applies when the subscriber and one or more dependents are enrolled. Prior to benefits being paid for any family member, the entire family deductible must be met.	$2,500 per member/$5,000 per family or $3,500 per member/$7,000 per family	
Lifetime maximum	$2,000,000 per member	
Annual Out-of-Pocket Amount The total amount of coinsurance and deductible amount you, or you and your family, are responsible to pay during a calendar year for covered services, after which the plan will provide 100% of the allowed amount for the remainder of that calendar year, unless otherwise specified. Any balances of charges not covered by this plan will be your, or you and your family's, responsibility to pay. The family out-of-pocket amount applies when the subscriber and one or more dependents are enrolled. Prior to benefits being paid for any family member at 100%, the entire family out-of-pocket maximum must be met.	$5,000 per member $10,000 per family	No out-of-pocket maximum
Professional Services Including diagnostic x-ray and laboratory. Coverage includes the services of physicians, osteopaths, naturopaths, and other eligible health care professional providers.	80% (unless specified otherwise)	60%
Hospital Facility (Inpatient and Outpatient)*** Including diagnostic x-ray and laboratory	80%	60%
Acupuncture 12 visits per calendar year maximum	80%	60%
Ambulance Services** Ground services: $2,000 per calendar year maximum	80%	80%
Blood Bank**	80%	80%
Home Health and Hospice Home Health – 130 visits per calendar year maximum Hospice – 6 months maximum	80%	80%
Home Medical Equipment $2,500 per calendar year maximum	80%	60%
Home Phototherapy	80%	80%
Infusion Therapy Growth hormone treatment is limited to $20,000 per calendar year	80%	60%
Mammography Routine mammograms not subject to deductible	80%	60%

(over)

Mental Disorders Inpatient – 8 days per calendar year Outpatient – 12 visits per calendar year	80%	60%
Occupational Injury (provided for the subscriber only)	80%	60%
Phenylketonuria (PKU) Formulas Not subject to waiting periods	80%	80%
Preventive Care (not subject to deductible)	80%	60%
Prostate Cancer Screening Routine prostate cancer screenings not subject to deductible	80%	60%
Prostheses and Orthotics	80%	60%
Rehabilitation Inpatient - $4,000 per calendar year maximum Outpatient - $2,000 per calendar year maximum	80%	60%
Skilled Nursing Facility 30 days per calendar year maximum	*	80%
Special Equipment and Supplies	80%	80%
Spinal Manipulations 10 manipulations per calendar year maximum	80%	60%
Transplants $350,000 lifetime maximum; 12-month waiting period	80%	60%

*At this time, this service is provided only by participating providers.
**At this time, these services are provided only by recognized providers.
***Services and supplies required to treat a medical emergency will be provided at the Preferred Plan payment level of benefits.

Cost Containment Provisions: All hospital and skilled nursing facility admissions must be medically necessary. Preadmission approval is required for all inpatient admissions outside the service area if you seek care from providers who have not contracted with a Blue Cross and/or Blue Shield plan, except for emergency services.

Emergency Care: Emergency benefits will be provided at the level specified for a Preferred Plan provider. In the event of a medical emergency, treatment by a provider not normally covered under this plan will be recognized for a 24-hour period or for such additional time as is reasonably required to come under the care of a Preferred Plan or participating provider. Benefits will be based on the recognized provider's actual charge for the service.

Care Outside the Service Area: All care received outside the service area will be paid the same as in the service area if you use a Preferred Plan or participating provider. Payment will be based on the allowed amount. To receive the highest benefit level, you must receive services from a Preferred Plan provider. If there is no Preferred Plan provider network in an area, benefits will be provided for care received from a participating provider at the level specified for Preferred Plan providers. Benefits will be provided for care received from a recognized provider at the level specified for Preferred Plan providers only, if there is no local Blue Cross and/or Blue Shield participating provider network in a particular area and for medical emergencies. Call 1-800-810-BLUE (2583) for names of Preferred Plan or participating providers with the local Blue Cross and/or Blue Shield plan. When you need health care outside of the United States or its territories, call the BlueCard Worldwide Service Center at 1-800-810-BLUE or call collect at 1-804-673-1177. If you are admitted to a hospital while traveling outside the service area, you must contact the Company within 24 hours to receive full plan benefits. If you meet all requirements, inpatient benefits will be provided at the level specified for Preferred Plan providers for like services and supplies.

Waiting Periods: No benefits are provided for treatment relating to a transplant until you have been covered under this plan for 12 consecutive months. This waiting period will be reduced by any time that you were covered under prior plan(s) that qualify as creditable coverage. No benefits will be provided for preexisting conditions until you have been covered under this plan for nine consecutive months, unless you were continuously covered for at least nine months under the immediately preceding creditable plan.

This is a brief summary of benefits; it is not a certificate of coverage. For full coverage provisions, including a description of waiting periods, limitations, and exclusions, refer to the plan contract. myRegence.com is designed to advise you on health care and lifestyle options, navigate you through the health care system, and reward you who make healthy choices. Go to www.myRegence.com and view claims; get fitness and nutrition tips; learn about medical conditions, medications and formulary information; search for doctors; and research cost and care options.